### Rawlings Community Counseling



6807 Cody Street, Bonners Ferry, Idaho 83805

Phone: 208-267-0900 Fax: 208-267-6100

# REGISTRATION FORM

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| Today’s date: PATIENT INFORMATION |
| Patient’s last name: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital status (circle one) |
| First: | Middle: | Single / Mar / Div / Sep / Wid |
| Street Address: |
| City: | State: | ZIP Code: | Age: |  |
| Social Security no.: | Birth date: / / | Sex: | ❑ M | ❑ F |
| Email: | Home phone no.: ( ) | Cell Phone No: ( )  |
| Occupation: | Employer: | Employer phone # ( ) |
| Father: Phone number:Mother: Phone number: |
| INSURANCE INFORMATION |
| **(Please give your insurance card to the receptionist.)** |
| **Person responsible for bill:** | Birth date: / / | Home phone no.: ( ) |
| Address (if different): |
| Is this person a patient here? | ❑ Yes | ❑ No | Occupation:  | SS#:  |
| **Employer**: | Employer phone no.: ( ) |
| Employer address: |  |
| **Is this patient covered by insurance**? | ❑ Yes | ❑ No | ❑ Medicaid #: | ❑ Other |
| Subscriber’s name: |  | Birth date: / / | Co-payment: $ |
| Subscriber’s S.S. no.: |  | Group no.: | Policy no.: |  |
| **Name of secondary insurance (if applicable**): |  | Group no.: | Policy no.: |
| Subscriber’s name: |  |  |  |
| Patient’s relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| Total household size and income if requesting sliding fee discount program: Proof of income required within 10 days of 1st visit:Until proof of income is received all visits will be billed at full price: |
| Members of the household:  |
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| Medical history |

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| Current Medications:  |
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|  |
| Current Diagnosis:  |
| Allergies:  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|  |  | ( ) | ( ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Rawlings Community Counseling. I understand that I am financially responsible for any balance. I also authorize RCC or insurance company to release any information required to process my claims. |
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|  | Patient/Guardian signature ( If Minor) |  | Date |  |